

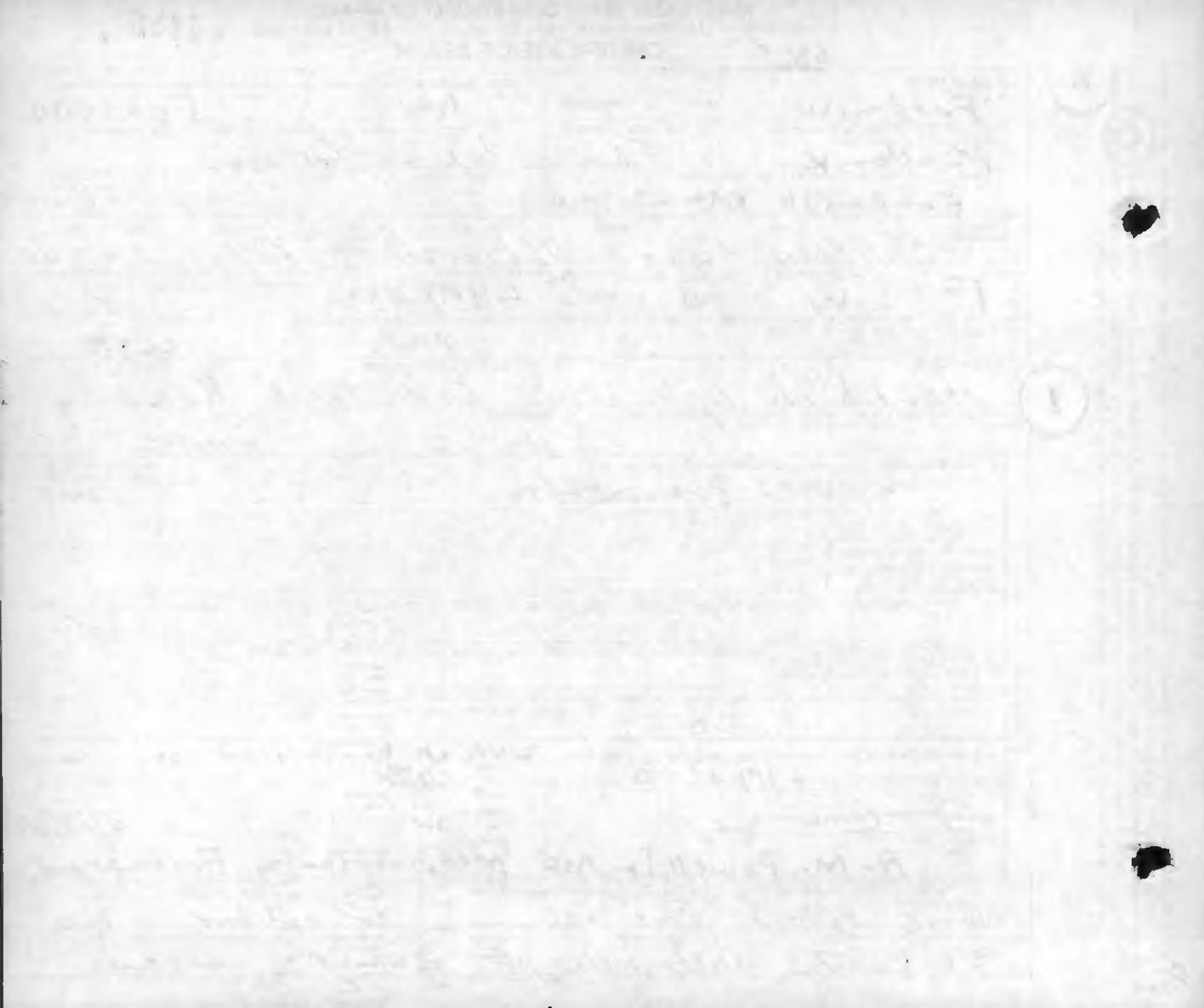
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

64486

CERTIFICATE OF DEATH

4526

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>5 hrs.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Frederick</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memoria Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Union Bridge</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Shelley Lynn Albaugh</i>		First <i>S</i>	Middle <i>h</i>	Last <i>Albaugh</i>	4. DATE OF DEATH <i>April 34 1960</i>	Month <i>Apr</i>	Day <i>34</i>	Year <i>1960</i>				
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>24 April 60</i>	9. AGE (in years last birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>Hezekiah Upton Albaugh</i>		14. MOTHER'S MAIDEN NAME <i>Betty Irene Keeney</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother</i>		Address <i>Same</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>						
776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Frederick</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>24 April 1960</i> to <i>24 May 1960</i> , that (I) (we) last saw the deceased alive on <i>24 April 1960</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.												
22a. SIGNATURE <i>D. Brown</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/24/60</i>		
22c. PHYSICIAN'S NAME (Type) <i>A. M. Powell, Jr. M.D.</i>		22d. ADDRESS <i>Medical Center, Frederick</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/26/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rocky Hill</i>		23d. LOCATION (City, town, or county) <i>Md.</i>		(State) <i>Md.</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i>		ADDRESS <i>Walkersville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 27 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14487
Reg. Dist. No.

4527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Year,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 6 West Third Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 West Third Street				d. STREET ADDRESS 6 West Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JENNIE		First JENNIE	Middle ESTELLE	Last BAKER	4. DATE OF DEATH April 14, 1870	Month April	Day 20,	Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 14, 1870	9. AGE (In years on birthday) 90	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Levin B. Johnson				14. MOTHER'S MAIDEN NAME Sarah C. Browning					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. Earle O. Baker-R.F.D.#2, McLean Virginia		Address Box #77			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident DUE TO 32IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
INTERVAL BETWEEN ONSET AND DEATH 2 weeks.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 2	Doy 1	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 2/18	(County) 1960	(State) 1960
21. I certify that I attended the deceased from 2/1 , 1960, to 2/18 , 1960, that I last saw the deceased alive on 2/18 , 1960, and that death occurred at 10:15 A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 9 E. Church St.									
DATE SIGNED 20 Apr 1960									
ACTUAL SIGNATURE Richard C. Reynolds		M.D. Richard C. Reynolds, M. D.							
PHYSICIAN'S NAME (Type)		Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1960		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Traud			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4566

CERTIFICATE OF DEATH

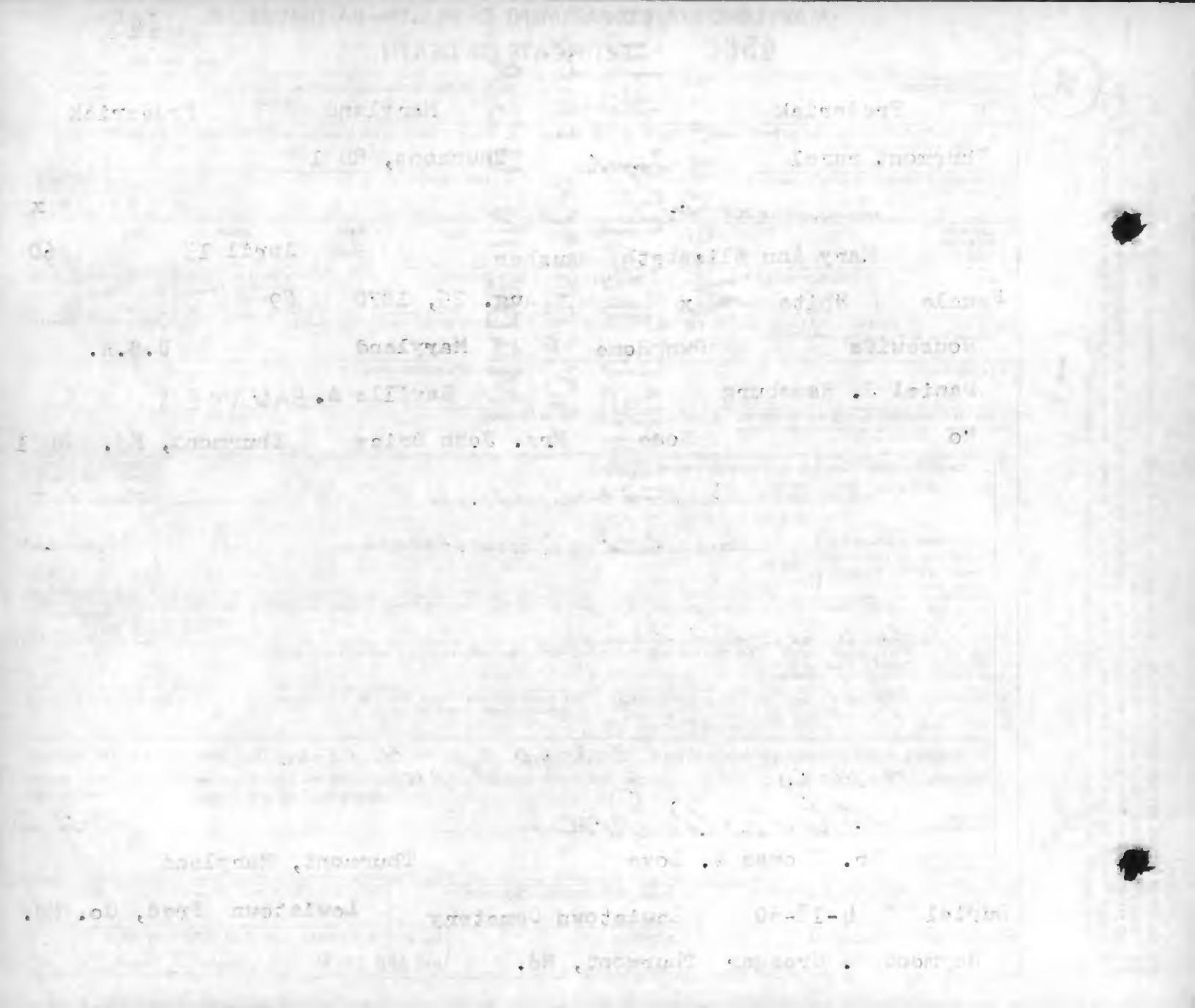
64488

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		c. LENGTH OF STAY IN lb 3 weeks-		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, RD 1		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thurmont Rd.				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary Ann Elizabeth Baugher		First	Middle	Last	4. DATE OF DEATH Month April 15	Day	Year 19 60
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1870		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel J. Ramsburg		14. MOTHER'S MAIDEN NAME Saville A. BAVGHER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or known) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. John Brice		Address Thurmont, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Thrombosis -</i> DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Generalized Cerebrovascular</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 weeks - 20 years -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Malnutrition - Dehydration</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-3-60</i> , 19, to <i>4-15-60</i> 19, that I last saw the deceased alive on <i>4-14-60</i> , 19, and that death occurred at <i>2:15 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Maryland DATE SIGNED <i>4-16-60</i>							
ACTUAL SIGNATURE <i>Thomas A. Love</i>		22. BURIAL, CREMATION, OR REMOVAL (Specify) Burial					
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		22b. DATE THEREOF 4-18-60					
24a. REC'D BY REGISTRAR DATE APR 20 '60		22c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery					
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		22d. LOCATION (City, town, or county) Lewistown Fred, Co. Md.					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4528 CERTIFICATE OF DEATH

64489

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b DAVS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WOODSBORO		d. STREET ADDRESS RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) FREDERICK MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VERNON	Middle OSCAR	Last BEARD	4. DATE OF DEATH Month APRIL	Day 25	Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/23/1891	9. AGE (In years, last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABIRER - COUNTY ROAD DEPT		10b. KIND OF BUSINESS OR INDUSTRY LABIRER - COUNTY ROAD DEPT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE BEARD		14. MOTHER'S MAIDEN NAME DELIA KEENEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-26-7722		17. INFORMANT Mrs ANNABELLE BEARD		Address RURAL Woodsboro Md	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO acute lower respiratory infection (c)							
INTERVAL BETWEEN ONSET AND DEATH years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m. 19		20d. INJURY OCCURRED White or work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/17 , 19 60 to 4/17 , 19 60 , that I last saw the deceased alive on 4/17 , 19 60 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) CHURCH ST. FREDERICK MD.							
DATE SIGNED 4/17/60							
ACTUAL SIGNATURE <i>Richard C Reynolds</i>	PHYSICIAN'S NAME (Type) RICHARD C REYNOLDS FREDERICK MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-27-60		22c. NAME OF CEMETERY OR CREMATORIAL Rocky Hill CEM		22d. LOCATION (City, town, or county) FREDERICK COUNTY MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Powell - Woodsboro Md</i>		ADDRESS <i>John Powell - Woodsboro Md</i>		24a. REC'D BY REGISTRAR DATE APR 28 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

STATE OF KANSAS - DIVISION OF MOTOR VEHICLES
CERTIFICATE OF REGISTRATION

5151

Owner: student name - incomplete name
and S. telephone number and street address

5147

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4529

CERTIFICATE OF DEATH

64490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Upper College Terrace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 200 East Church Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CATHERINE		First CATHERINE	Middle BEALL	Last BESANT	4. DATE OF DEATH April	Month Month	Day 10,	Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1898		9. AGE (in years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Reid Besant		14. MOTHER'S MAIDEN NAME Emily March							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-22-7550		INFORMANT Mrs. Margaret B. Newman- Same as Item #1		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8		DUE TO Metastatic carcinoma of colon		INTERVAL BETWEEN ONSET AND DEATH 8 years					
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b)		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 4/10		(County) 1960	(State) Frederick, Maryland
21. I certify that I attended the deceased from alive on 4/8, 1960 , and that death occurred at 6:46 A.M.									
ACTUAL SIGNATURE James B. Thomas,		M.D. Professional Building		ADDRESS (Street, city or town, state) Frederick, Maryland		DATE SIGNED 4/11/60			
PHYSICIAN'S NAME (Type) James B. Thomas, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 12, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick,		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Arthur L. Kraus		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			
				DATE APR 14 '60					

153.8

tem 18 Film 2614 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. 6491

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the physician for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the Sheriff, Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		a. STATE Maryland b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b		Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Frederick Memorial Hospital		//Frederick	
e. STREET ADDRESS		56 Carver Apt.		d. STREET ADDRESS	
f. IS RELICEN'E ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month
Ray		Micheal	Biggus	April	Day
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 14 YEARS Months Days Hours Min
M	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 23, 1959	9 yrs	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Frederick Co.	
12. CITIZEN OF WHAT CO INTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Stanley R Biggus		Mary Ann Rollins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Stanley R. Biggus, Frederick, Md,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Meningo-encephalitis probably virus origin			
092X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.		DUE TO Hepatitis probably virus origin			
DUE TO (c)		Interstitial pneumonitis probably origin			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE THEREOF			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED April 12, 1960			
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF April 14-60			
22c. NAME OF CEMETERY OR CREMATORIAL Fairview		22d. LOCATION (City, town, or county) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C.E.Hicks 111, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 18 '60			
		24b. REG STAR'S SIGNATURE Arthur S. Krause			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it, certifying, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4492

4563

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural—Ijamsville

c. LENGTH OF STAY IN TB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Off Rt 80 nr Rt. 75

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

April 11

1960

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Junk Dealer

7. MARRIED NEVER MARRIED b. DATE OF BIRTH

WIDOWED

DIVORCED

Dec. 4, 1905

9. AGE (In years
from birthday)

54

yes

10. IF UNDER 1 YEAR

Months Days

Hours Min.

13. FATHER'S NAME

Oscar Brandenburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-24-7361

17. INFORMANT

Mrs. Lucille Brandenburg, Monrovia, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

973.3

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Carbon Monoxide Poisoning

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

1. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

B. O. Thomas

DATE SIGNED

EXAMINER'S
NAME (Type)

B. O. Thomas

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

4/11/60

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

4/13/60

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

Providence Meth.

22d. LOCATION (City, town, or county)

(State)

Kempton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Olin L. Mobsomth

ADDRESS

Damascus, Md.

24a. REC'D BY REGISTRAR

DATE APR 13 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

773X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4531

CERTIFICATE OF DEATH

14493

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 W. College Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Monroe Brehaut		First Margaret	Middle Monroe
4. DATE OF DEATH April 22, 1960	Month April	Day 22	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gas Co. Official		10b. KIND OF BUSINESS OR INDUSTRY Portland Maine	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Monroe		14. MOTHER'S MAIDEN NAME Margaret Biersto	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-32-4518	
17. INFORMANT Mr. Raymond C. Brehaut		Address 303 W. College Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Gastro-intestinal hemorrhage cause undetermined</i> <i>1 month</i>	
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>april 22, 1960</i>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1956</i> , to <i>april 22, 1960</i> , that I last saw the deceased alive on <i>april 21, 1960</i> , and that death occurred at <i>1025 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4/23/60</i>			
ACTUAL SIGNATURE <i>Henry V Chase M.D.</i>			
PHYSICIAN'S NAME (Type) Dr. H. V. Chase			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-1960	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Gailey Jr.</i>		24a. REC'D BY REGISTRAR APR 26 '60	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Tracy</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4532

CERTIFICATE OF DEATH

6494

Reg. Dist. No.

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town) FREDERICK 2 hrs		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Frederick Memorial Hospital					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Year
Bayard			Cleveland	Burgess	Apr 19 1960.
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19 1884
Male		White			9. AGE (In years last birthday) 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
Retired Merchant		Grocery Store		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Burgess		14. MOTHER'S MAIDEN NAME Mary Lare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-16-0155		INFORMANT Lewis Burgess New Market Md	
17. ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 18 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Undetermined			
		DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>60</u> , to <u>4/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/15/60</u> , 19 <u>60</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 278 N. Market St. Frederick, Md.			
ACTUAL SIGNATURE James B. Thomas		DATE SIGNED 4/16/60			
PHYSICIAN'S NAME (Type) James B. Thomas					
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 18, 1960	22c. NAME OF CEMETERY OR CREMATORIUM New Market Cemetery	22d. LOCATION (City, town, or county) New Market Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lucian K. Falconer		ADDRESS New Market Md		24a. REC'D BY REGISTRAR DATE APR 20 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64495

4568 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville		c. LENGTH OF STAY IN 1b life		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville		d. STREET ADDRESS Route # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JACOB		First	Middle ELMER	Last CLINE	4. DATE OF DEATH April 10	Month April	Day 10	Year 1960	
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 17, 1874		9. AGE (In years lost birthday) 85 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY own gen. farm		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Cline		14. MOTHER'S MAIDEN NAME Catherine Summers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		INFORMANT Grayson R. Cline, Myersville, Md. Rt. #1		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Massive Cerebral Hemorrhage							
731X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)							
		DUE TO (c) Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>April 10</u> , 1960, to <u>April 10</u> , 1960, that I last saw the deceased alive on <u>April 10, 1960</u> , and that death occurred at <u>Middleton</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED <u>April 11, 1960</u>							
ACTUAL SIGNATURE <u>J. Elmer Harp</u>		M.D.							
PHYSICIAN'S NAME (Type) J. Elmer Harp		Middletown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 12, 1960		22c. NAME OF CEMETERY OR CREMATORIUM St. John's Lutheran		22d. LOCATION (City, town, or county) Nr. Myersville, Fred. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>		ADDRESS Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR DATE APR 12 '60		24b. REGISTRAR'S SIGNATURE <u>John S. Harp</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4300 CERTIFICATE OF DEATH

1-4495

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 11		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 FREDERICK		d. STREET ADDRESS 608 MARY STREET				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First BABY	Middle 	Last COOK	4. DATE OF DEATH APRIL 11, 1960	Month APRIL	Day 11	Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 11, 1960	9. AGE (In years last birthday) yrs. 45	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS Days —	Hours —	Min. —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME RAYMOND COOK JR.		14. MOTHER'S MAIDEN NAME VIRGINIA LEE WILLIS								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT MOTHER - 608 MARY ST. - FREDERICK, MD.		Address —				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776 X		DUE TO PREMATURITY - 5 MONTHS		INTERVAL BETWEEN ONSET AND DEATH —						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. —		(b) DUE TO APPENDECTOMY ON MOTHER								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) —								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —	
21. I certify that (I) (this hospital) attended the deceased from 4/11 1960, to 4/11 1960, that (I) (we) last saw the deceased alive on 4/11 1960, and that death occurred at 2:45 AM from the causes and on the date stated above.										
22a. SIGNATURE Byron D. White		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4/14/60						
22c. PHYSICIAN'S NAME (Type) Byron D. WHITE		22d. ADDRESS 115 W. BROAD ST., FREDERICK, MD.								
23a. BURIAL CREMATION: REMOVAL (Specify) Burial		23b. DATE THEREOF 4-13-60		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City, town, or county) Frederick, Maryland		(State) —		
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS —		25a. REGISTRATION NO. 1374147480		25b. REGISTRAR'S SIGNATURE Arthur S. Krause		DATE APR 14 '60		

7768

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4534

CERTIFICATE OF DEATH

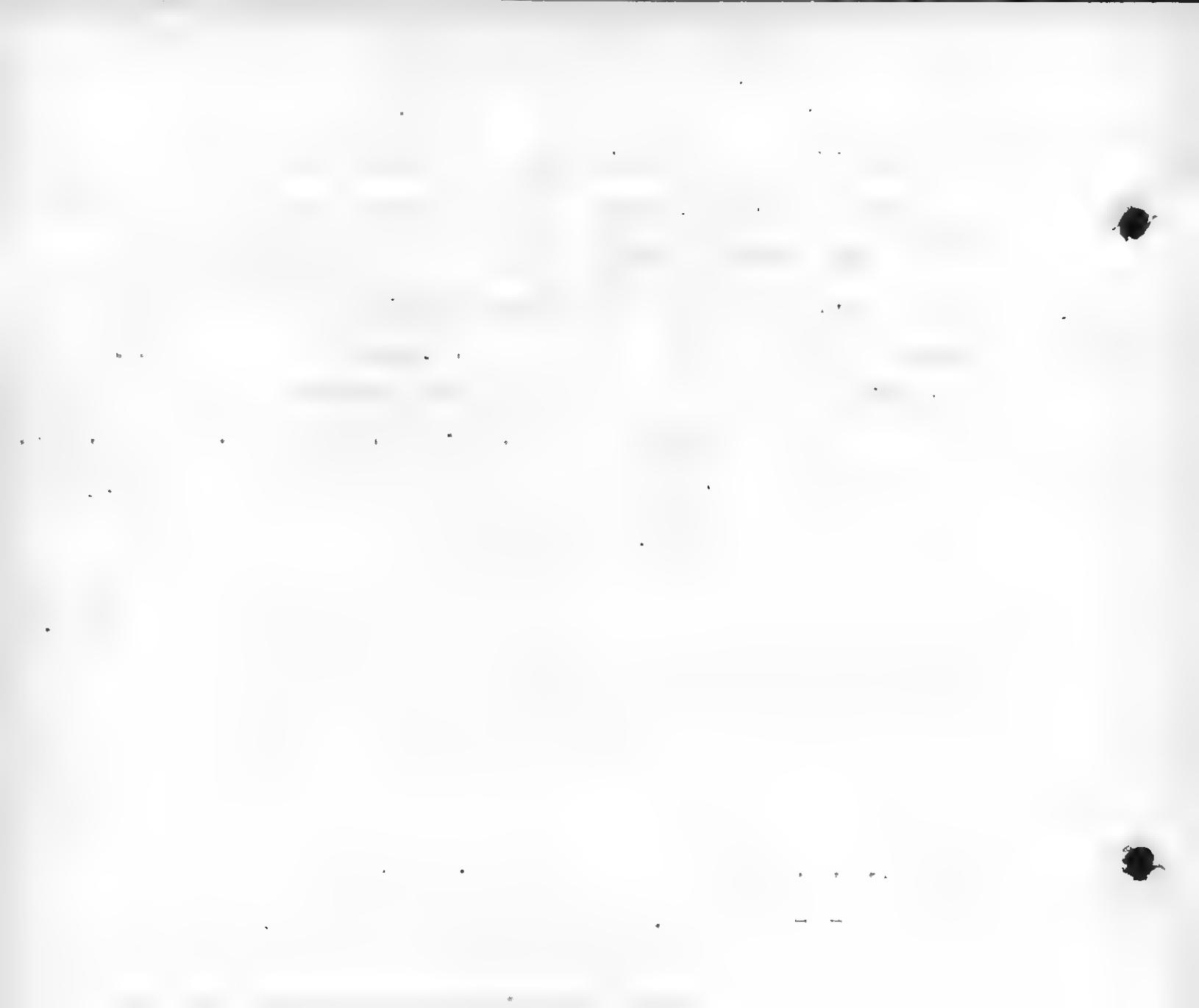
Reg. Dist. No. 1497

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 40 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. STREET ADDRESS Frederick Route # 1	
3. NAME OF DECEASED (Type or print) Eva Musetta Cray		4. DATE OF DEATH Month April 24, 1960	Year Day Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) W. Virginia
13. FATHER'S NAME Frank Daniels		14. MOTHER'S MAIDEN NAME Amanda Jane Maze	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	INFORMANT Mrs. Ardella A. Urie
			Address 830 N. Market Sr. Fred.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hernia</i> <i>ruptured</i> <i>inflammation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>infection</i> <i>tree</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify, that I attended the deceased from <i>1960</i> , to <i>1960</i> , that I last saw the deceased alive on <i>1960</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>E. A. Dettbarn</i>		ADDRESS (Street, city or town, state) <i>Walkersville, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-1960	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey Jr.</i>		24a. REC'D BY REGISTRAR DATE APR 28 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Knapp</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4535

CERTIFICATE OF DEATH

64498

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbamyl paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick																																																																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick																																																																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 500 Military Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																			
3. NAME OF DECEASED (Type or print) William		First	Middle Browning	Lost	4. DATE OF DEATH April 21, 1960	Month April	Day 21	Year 1960																																																															
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1898	9. AGE (In years last birthday) 61	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min. 0																																																																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucking Business		10b. KIND OF BUSINESS OR INDUSTRY Trucking Business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.																																																																	
13. FATHER'S NAME A. Winsor Davis				14. MOTHER'S MAIDEN NAME Nora Browning																																																																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 22016-3316		INFORMANT Mrs. Mabel E. Davis		Address 500 Military Road Fred.																																																																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]																																																																							
<table border="0"> <tr> <td colspan="2">PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</td> <td colspan="7"><i>Acute thrombotic occlusion of left coronary artery</i></td> </tr> <tr> <td colspan="2">DUE TO</td> <td colspan="7">INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i></td> </tr> <tr> <td colspan="2">Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</td> <td colspan="7">DUE TO</td> </tr> <tr> <td colspan="2">{</td> <td colspan="7"><i>Acute myocardial infarction</i></td> </tr> <tr> <td colspan="2">(b)</td> <td colspan="7">INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i></td> </tr> <tr> <td colspan="2">{</td> <td colspan="7">DUE TO</td> </tr> <tr> <td colspan="2">(c)</td> <td colspan="7"></td> </tr> </table>									PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Acute thrombotic occlusion of left coronary artery</i>							DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>							Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO							{		<i>Acute myocardial infarction</i>							(b)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>							{		DUE TO							(c)								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Acute thrombotic occlusion of left coronary artery</i>																																																																					
DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>																																																																					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO																																																																					
{		<i>Acute myocardial infarction</i>																																																																					
(b)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>																																																																					
{		DUE TO																																																																					
(c)																																																																							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																																																																					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f. (City or town) Frederick	(County) Maryland	(State) Md.																																																														
21. I certify that I attended the deceased from April 21, 1960 to April 24, 1960 that I last saw the deceased alive on April 21, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.																																																																							
ADDRESS (Street, city or town, state) Frederick, Maryland																																																																							
DATE SIGNED April 24, 1960																																																																							
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D.																																																																					
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr.		M.D. 228 North Market Street Frederick, Md.																																																																					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-1960		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State) Md.																																																															
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Riley Jr.</i>		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR Arthur S. Thomas		24b. REGISTRAR'S SIGNATURE																																																																	
				DATE APR 28 '60																																																																			

- 19

L-4-8481
L-4-9681
b:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4536

CERTIFICATE OF DEATH

4499

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 20 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 503 Fairview Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARK Middle LAVIER DELAUTER		4. DATE OF DEATH Month April Day 12, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6 Jan 1916
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent & Salesman		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Insurance Company, Doubs, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter H. DeLauter		14. MOTHER'S MAIDEN NAME Myra N. Whipp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO 215-10-7544	
17. INFORMANT Mrs. Helen W. DeLauter (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153-3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Adenocarcinoma of Sigmoid		INTERVAL BETWEEN ONSET AND DEATH 153-3 Oct. 1950	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 228 N. Market St.		20f. (City or town) (County) (State) Frederick, Maryland	
21. I certify that I attended the deceased from 1957 to 12 APR 1960, that I last saw the deceased alive on 11 APR 1960, and that death occurred on 11 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Charles H. Conley, Jr., M.D.		ADDRESS (Street, city or town, state) 22. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M.D.		DATE SIGNED 13 Apr 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-60	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 18 '60	
		24b. REGISTRAR'S SIGNATURE Catherine S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 184500

4537 CERTIFICATE OF DEATH

Reg. Dist. No.

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 401 Rockwell Terrace		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 Rockwell Terrace						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MABEL		First P.	Middle 	Last DERTZBAUGH	4. DATE OF DEATH April 28, 1960	Month April	Day 28	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1884	9. AGE (In years lost birthday) 75 yrs	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Henry Dertzbaugh			14. MOTHER'S MAIDEN NAME Emma I. Bennett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. Lewis R. Dertzbaugh-Frederick, Maryland		5 West Church Street		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissection DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Rupture of Anruism of Ascending Aorta (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 	(County) 	(State)
21. I certify that I attended the deceased from April 28, 1960 to April 28, 1960 , that I last saw the deceased alive on April 28, 1960 , and that death occurred at 8:45 PM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 								
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D Professional Building							
DATE SIGNED 4/30/1960								
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 30, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATED ON (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS 		24a. REC'D BY REGISTRAR MAY 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4538

CERTIFICATE OF DEATH

64501
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 120 East Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital									
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Last	4. DATE OF DEATH Month April	Day 2, 1960	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1900	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME I. Myrtlelin Dutrow				14. MOTHER'S MAIDEN NAME Mary Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 220-16-4125		17. INTERVIEWER Mrs. Mary P. Dutrow (wife) 120 E. Third St.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		Acute Monocytic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 6 months					
{ (b) DUE TO { (c)		Bronchopneumonia		6 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE B. O. Thomas		M.D.		April 4, 1960					
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Sr.		N.D. 228 North Market Street, Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-1960		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey Jr.		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 4539 CERTIFICATE OF DEATH

64562

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge,		d. STREET ADDRESS BARK HILL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harry		First	Middle T.	Last Eckard	4. DATE OF DEATH April 13 1960	Month	Day	Year	
S SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 24-1871	9. AGE (In years last birthday) 88 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Jacob Eckard		14. MOTHER'S MAIDEN NAME Ella Amanada		15. INFORMANT ANGEL		16. SOCIAL SECURITY NO 220-16-2985			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		19. INTERVAL BETWEEN ONSET AND DEATH 1 day		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		DUE TO Bilateral Pneumothorax		21. (b) Fractures of rt 7-10 ribs and left 2nd-Prob. Patho- logical Fr.		22. (c) 2 days			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 4113		(County) 4113	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 4/14/60 to 4/13 , 1960, that (I) (we) last saw the deceased alive on 4/17/60 , and that death occurred at 4/13 M, from the causes and on the date stated above.		22b. DATE SIGNED 4/13/60		22c. PHYSICIAN'S NAME (Type) Frank Damazo M.D.		22d. ADDRESS 7 W. 3rd st Frederick, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/60		23c. NAME OF CEMETERY OR CREMATORIUM CHURCH OF GOD CEM.		23d. LOCATION (City, town, or county) UNIONTOWN MARLTON		(State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Frank Damazo Union Bridge Md		25a. ADDRESS 833 Main St Union Bridge Md		25b. REC'D BY REGISTRAR DATE APR 18 '60		25c. REGISTRAR'S SIGNATURE Arthur S. Chase			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64503

Reg. Dist. No.

4540

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. To FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the remains prior to burial or removal.

VS. A15ME(5)
SM 9/55

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)								
Frederick MARYLAND		Frederick		12 hrs		Frederick Memorial Hospital		a. STATE Maryland b. COUNTY Frederick								
								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
								Legore								
								d. STREET ADDRESS								
								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
069		First Shirley		Middle Irene		Last Eckenrode		4. DATE OF DEATH	Month April	Day 7,	Year 1960					
3. NAME OF DECEASED (Type or print)								5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
Female		White		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Oct. 10, 1953	6 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				
Student				None				Maryland				U.S.A.				
13. FATHER'S NAME Claude W. Eckenrode								14. MOTHER'S MAIDEN NAME Mary Morgan								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address				
No				None				Hospital Records								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u>																
812 X DUE TO																
Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last. (b)																
(c)																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
Child darted into path of automobile on highway																
20c. TIME OF INJURY Hour 8:25 a.m. Month, Day, Year Apr 7 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Nr. Woodsboro, Frederick, Md				
												(County)				
												(State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																
ACTUAL SIGNATURE <u>B. O. Thomas</u> DATE SIGNED 4.8.60																
EXAMINER'S NAME (Type) B. O. Thomas, M. D.																
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/1960		22c. NAME OF CEMETERY OR CREMATORIUM Chapel		22d. LOCATION (City, town, or county) Nr. Liberytown		(State) Md								
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Martin</u>																
ADDRESS Walkersville								24a. REC'D BY REGISTRAR APR 12 '60				24b. REGISTRAR'S SIGNATURE <u>John S. Tracy</u>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64564

Reg. Dist. No.

4541

CERTIFICATE OF DEATH

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 East Church Street		e. STREET ADDRESS 6 East Church Street	
3. NAME OF DECEASED (Type or print) MARSHALL		First LINGAN	Middle ETCHISON
4. DATE OF DEATH Month April		Month 30,	Day Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> XX	8. DATE OF BIRTH April 18, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Music	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William H. B. Etchison		14. MOTHER'S MAIDEN NAME Josephine Pearre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unk	INFORMANT Address Miss. Josephine Etchison (same as item #2)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 24, 1960 , to April 30, 1960 , that I last saw the deceased alive on April 30, 1960 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. Austin Pearre</i>		ADDRESS (Street, city or town, state) 4 East Church Street	
PHYSICIAN'S NAME (Type) Dr. A. Austin Pearre		DATE SIGNED 5/2/60	
22a. BURIAL, CREMATION OR REMOVAL (Specify) burial		22b. DATE THEREOF 5/3/60	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAY 6 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>



Item 20 Film 261 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4505

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4542

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN Tb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)First
EllaMiddle
MayLast
Flook4. DATE
OF
DEATHMonth
AprilDay
17,Year
19 60

5. SEX

Female

6. COLOR OR RACE
White7. MARRIED NEVER MARRIED 8. DATE OF BIRTH
WIDOWED DIVORCED

11/11/1870

9. AGE (in years
last birthday)
89 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John H. Himes

14. MOTHER'S MAIDEN NAME

Sarah C. Stine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give year or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none Alden Flook, 106 Catoctin Ave., Frederick

Address

INTERVAL BETWEEN
ONSET AND DEATH
3 hrs.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Traumatic shock

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Congestive heart failure; Arteriosclerotic H. D.

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

fell down flight of stairs No one knows how she struck
left shoulder causing injury20c. TIME OF INJURY Month, Day, Year
1 Hour p.m. 4-17 19 6020d. INJURY OCCURRED
White at work Not white at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
Home

20f. (City or town)

(County)

(State)

Brunswick Frederick Md

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATURE

B. O. Thomas

DATE SIGNED

EXAMINER'S
NAME (Type)

B. O. Thomas, M. D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

4.18.60

22a. BURIAL, CREMATION, ETC.
Specify

Burial

22b. DATE THEREOF

4/20/1960

22c. NAME OF CEMETERY OR CREMATORIUM

Lutheran Cemetery

22d. LOCATION (City, town, or county)

(State)

Middletown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Gladhill Company, Middletown, Md.

24a. REC'D BY REGISTRAR

(State)

APR 21 1960

DATE

C. B. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4543

CERTIFICATE OF DEATH

64506

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 1½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS W. Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Mrs Mary Etta</i>	Middle <i>Flory</i>	4. DATE OF DEATH April 13 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1874
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Goods Store		10b. KIND OF BUSINESS OR INDUSTRY Proprietor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Ditto		14. MOTHER'S MAIDEN NAME Elizabeth Oliver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. A.D. Flory		Address Thurmont, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>			
DUE TO 422.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <i>Arteriosclerotic Heart Disease</i>			
DUE TO (c) <i>Arteriosclerosis (Senile)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 13 1960</i> to <i>April 13 1960</i> , that (I) (we) last saw the deceased alive on <i>April 13 1960</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>April 13, 60</i>	
22a. SIGNATURE <i>A. A. Pearre</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A. A. Pearre		22d. ADDRESS 4 E. Church St. Frederick, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-60	
23c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery		23d. LOCATION (City, town, or county) Clearspring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Creager</i>		ADDRESS Thurmont, Md.	
25a. REC'D BY REGISTRAR DATE APR 18 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Flory</i>	

420.1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

FOR STATE
HEALTH DEPT.

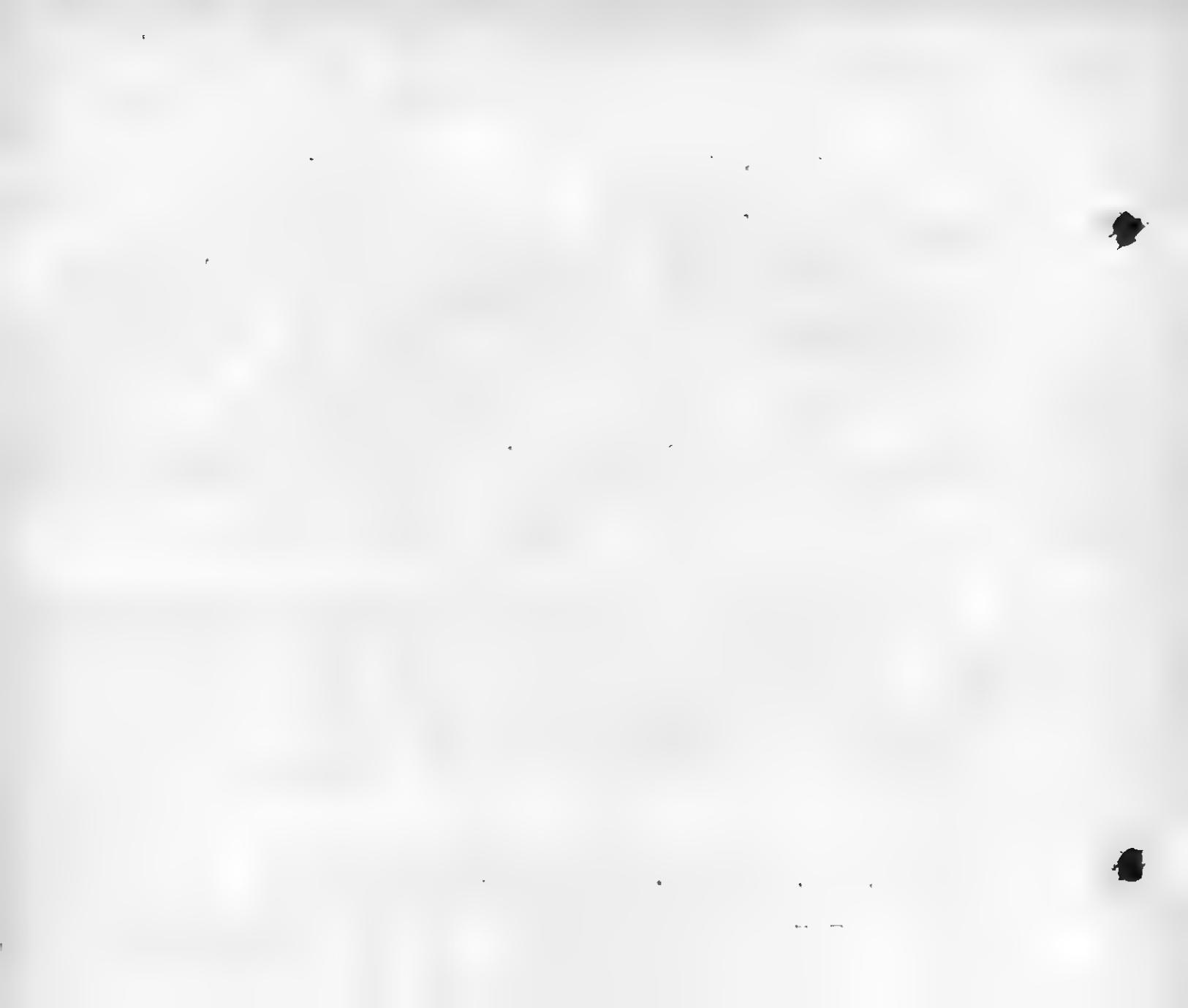
M

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived—If instit. or Res. before admission)		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Frederick Rt. # 3		35 years		Frederick Route # 3		Frederick Route # 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Frederick Rt. # 3		e. IS RESID... ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Day	Year
Roger		William	Fogle	April 19,		19	60
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1 YEAR Months Days Hours Min.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 7, 1917	43 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Operated Grocery Store				Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
George M. Fogle		Caroline Esterley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
No		217-10-0615		Mrs. Katherine B. Fogle Route # 3 Frederick		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20f. (City or town)		(County)		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Dr. B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 19, 1960	
EXAMINER'S NAME (Type)		22c. NAME OF CEMETERY OR CREMATORIUM Frederick Memorial Park		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
22a. BURIAL / CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-60		24a. REC'D BY REGISTRAR Arthur E. E. Thomas		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. E. Thomas		ADDRESS Frederick, Maryland		DATE APR 22 '60			
VS. ATISME 5M 2/57							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4544

CERTIFICATE OF DEATH

64568

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>60 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
3. NAME OF DECEASED (Type or print) <i>BARRY</i>		d. STREET ADDRESS <i>154 Carver Lfts.</i>	
3. NAME OF DECEASED (Type or print) <i>BARRY</i>	First <i>C</i>	Middle <i>C</i>	Last <i>GREEN</i>
4. DATE OF DEATH Month <i>April</i>	Day <i>23</i>	Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-15-60</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Frederick - Md.</i>	
13. FATHER'S NAME <i>Lawrence M. Green</i>		14. MOTHER'S MAIDEN NAME <i>Ann Galvin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
16. SOCIAL SECURITY NO.		17. INFORMANT	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Encephalitis</i>			
DUE TO (c) <i>Acute uremia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <i>8</i> a.m. <i>p.m.</i> 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Frederick</i> (County) <i>Md.</i> (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>22 April 1960</i> to <i>23 April 1960</i> that (I) (we) last saw the deceased alive on <i>23 April 1960</i> and that death occurred at <i>6 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Frederick</i>		22b. DATE SIGNED <i>23 April 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>FRED J. HELDRICH</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS <i>Frederick, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4-24-60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fairview</i>		23d. LOCATION (City, town, or county) <i>Frederick - Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Hicks III</i>		25a. REC'D BY REGISTRAR DATE <i>APR 27 '60</i>	
ADDRESS <i>Frederick - Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Author L. Thomas</i>	

1960-1961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4545

CERTIFICATE OF DEATH

64569

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 East Seventh Street				d. STREET ADDRESS 25 East Seventh Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle ROBERT	Last GROFF, JR.	4. DATE OF DEATH April	Month	Day 23,	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1954	9. AGE (in years at birthday) 5	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Robert Groff, Sr.				14. MOTHER'S MAIDEN NAME Jean E. Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO None		INFORMANT Mr. J. Robert Groff, Sr., - Same as Item #2	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 089 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO (d) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 2-2-1958 to 4-23-1960, that I last saw the deceased alive on 4-22-1960, and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Rex R. Martin M.D. 220 North Market Street Frederick, Maryland DATE SIGNED 4/26/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 26, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) Frederick Co., Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Echison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 28 '60		24b. REGISTRAR'S SIGNATURE Charles S. Krause	

41-4

to a visit to the
University of
Michigan.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4546

CERTIFICATE OF DEATH

64510
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 21 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wynelle Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
3. NAME OF DECEASED (Type or print) MARY Edith		d. STREET ADDRESS E. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF DEATH Grumbine Dec. 20, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John A. Grumbine		14. MOTHER'S MAIDEN NAME Ida G. Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	INFORMANT Mrs. Claude O'Toole
17. MEDICAL CERTIFICATION		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral thrombosis with infarction of the brain</i> DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>5 yrs</i> DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 1958</i> to <i>April 24, 1960</i> that I last saw the deceased alive on <i>April 23, 1960</i> , and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Henry V. Chase</i> M.D. <i>4 E. Church St</i> DATE SIGNED <i>4/24/60</i> PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i> <i>Frederick Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-60	22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Catholic Cem.
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE APR 27 '60
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Haas</i>	



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12
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64511

4547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 7 years		d. STREET ADDRESS 923 N. Market Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Constance Elizabeth Hart		4. DATE OF DEATH Month April Day 9 Year 1960	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1953	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Maryland	
10c. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis A. Hart Jr.		14. MOTHER'S MAIDEN NAME Floranna Stamper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Francis A. Hart Jr. Frederick, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 912.4 DUE TO Conditions, if any, which gave rise to immediate cause (b)		Fractured Skull	
DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Fell under a moving roller		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 9-30 4/9/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Staley Park		20f. (City or town) (County) (State) Frederick, Frederick, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 9, 1960	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		22e. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) Frederick - Maryland	
22e. DATE THEREOF 4-12-1960		22e. DATE THEREOF MAY 5 '60	
23. FUNERAL DIRECTOR'S SIGNATURE Daleys Funeral Home By C. Zink		24b. REGISTRAR'S SIGNATURE C. Zink	
ADDRESS Frederick - Maryland		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be referred to your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4570

CERTIFICATE OF DEATH

14512
Reg. Dist. No.

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Creagerstown		c. LENGTH OF STAY IN lb 10ye	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Creagerstown	
3. NAME OF DECEASED (Type or print) Margaret Riefel		First Middle Last Hawkins	4. DATE OF DEATH Month April 8, 1960 Day 19 Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Austin Riefel		14. MOTHER'S MAIDEN NAME Mary Fedick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	INFORMANT Fred Hawkins
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days Paralytic ileus-intestinal obstruction	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 26</u> , 19 <u>60</u> , to <u>Apr. 4</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Apr. 4</u> , 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE James K. Gray		ADDRESS (Street, city or town, state) Thurmont - Md DATE SIGNED	
PHYSICIAN'S NAME (Type) James K. Gray		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 4-11-60		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Presbyterian Cem	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR APR 12 '60 DATE
		24b. REGISTRAR'S SIGNATURE Loring S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64513

4548

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this cert. form has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-trouss permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institut. or residence before admis. on)	
		a. STATE Maryland	b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 220 East Third Street		d. STREET ADDRESS 220 East Third Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES		First LEWIS	Middle WHITMORE
		Last HILDEBRAND	4. DATE OF DEATH April
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 12, 1891	9. AGE (In years last birthday) 68 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles R. Hildebrand		14. MOTHER'S MAIDEN NAME Marietta Whitmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. E. Grace Cline- Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Lesions of Arteries, clots</i> DUE TO (c) <i>Arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Went to church</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Jefferson</i> (County) Maryland (State)	
21. I certify that I attended the deceased from <i>4/14/60</i> to <i>4/18/60</i> , that I last saw the deceased alive on <i>4/17/60</i> , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Jefferson, Maryland</i> DATE SIGNED <i>4/19/60</i>			
ACTUAL SIGNATURE <i>A. T. Brice, M.D.</i>			
PHYSICIAN'S NAME (Type) A. T. Brice, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 22 '60	
		24b. REGISTRAR'S SIGNATURE <i>Clara S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18514

4549

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		d. STREET ADDRESS FREDERICK, MARYLAND.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAUDIE	Middle BULINA	Last HINDMAN
4. DATE OF DEATH	Month April	Day 22,	Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1875.
9. AGE (In years lost birthday) 85 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse	11. KIND OF BUSINESS OR INDUSTRY Nursing	12. BIRTHPLACE (State or foreign country) Butler County Penn.
13. FATHER'S NAME AMOS HALL	14. MOTHER'S MOTHER'S NAME ANGELINA HALL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.	16. SOCIAL SECURITY NO. None	17. INFORMANT Kenneth H. Hindman	18. ADDRESS Son 919, Cherokee Trail
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO <i>Abdominal aortic aneurysm</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a) (b) ONSET AND DEATH <i>5 years</i>			
cause (a), stating the underlying cause lost. (c) DUE TO <i>with hemorrhage</i> 3 days.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/19 , 1960, to 4/22 , 1960, that I last saw the deceased alive on 4/2 , 1960, and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, City or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>J. McElroy</i>	PHYSICIAN'S NAME (Type) L. R. Schoolman M.D. 228, N. Market St. Frederick, Md.		
22a. BURIAL, CREMATION (Specify) REMOVAL	22b. DATE THEREOF APR. 23, 60	22c. NAME OF CEMETERY OR CREMATORIUM West Sunbury	22d. LOCATION (City, town, or county) West Sunbury Penn. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. McElroy</i>	ADDRESS DAILEY'S FUNERAL HOME	24a. REC'D BY REGISTRAR DATE APR 26 '60	24b. REGISTRAR'S SIGNATURE <i>J. McElroy</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64515

4550

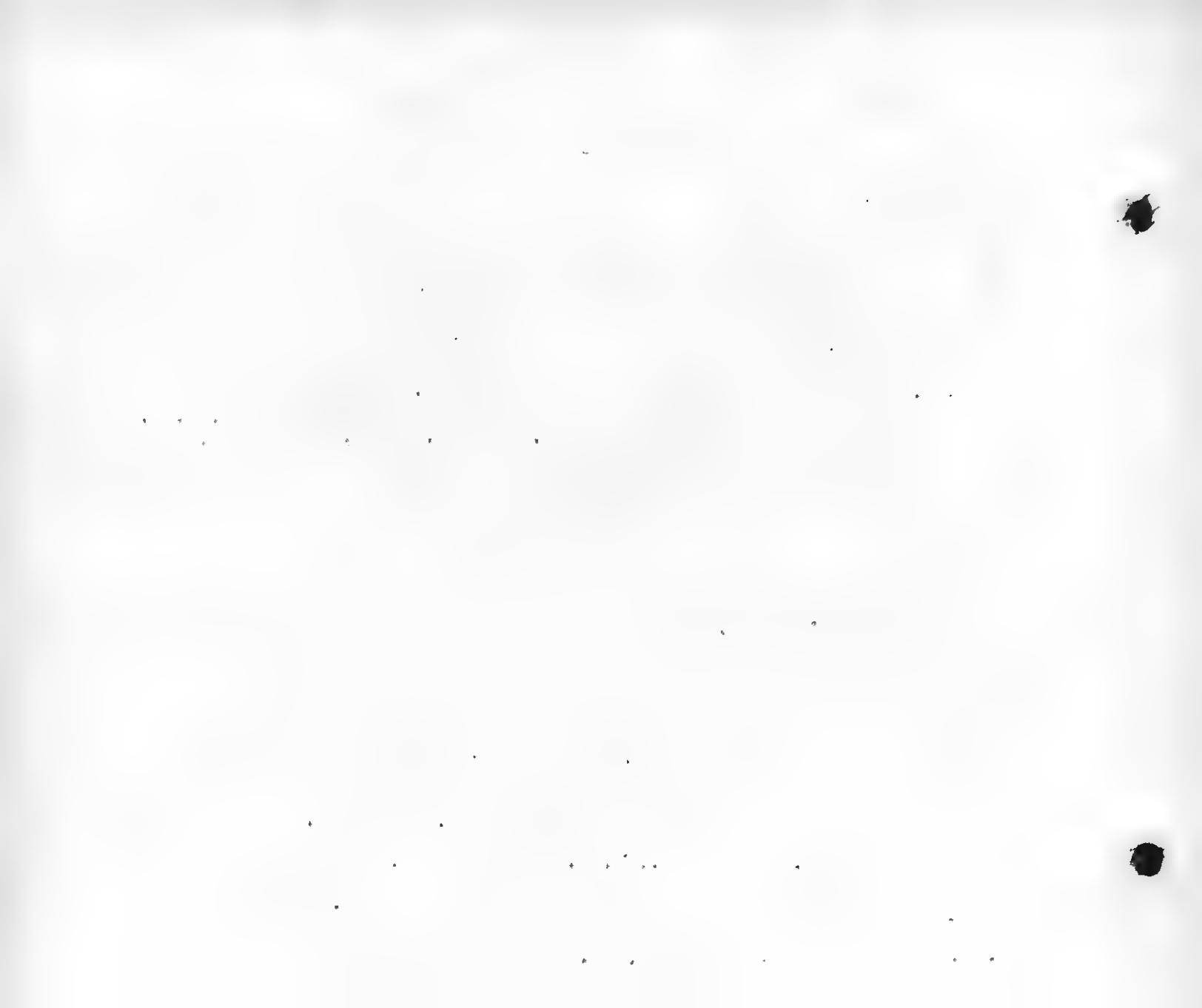
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY (In 1b) Since 4-30-59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wynelle Nursing Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle HASLUP	Last JOHNSON	4. DATE OF DEATH	Month April 23,	Day 19 60
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 3 June 1871	9. AGE (In years last birthday) 88	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin B. Johnson		14. MOTHER'S MAIDEN NAME Sarah C. Browning					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown. No		16. INFORMANT Mr. Earle O. Baker, McLean, Va.		INFORMANT Box 77, Adm. F. D. #2,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days			
-31X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Cerebral arter. sclerosis		10 years			
DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Diabetes Mellitus		15 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 1	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Beallsville	(County) Maryland
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>April 23</u> , 19 <u>60</u> that I last saw the deceased alive on <u>April 22</u> , 19 <u>60</u> , and that death occurred at <u>5:30A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 25 April 1960	
ACTUAL SIGNATURE <i>Bernard O. Thomas Jr.</i>		M.D. 228 N. Market St.					
PHYSICIAN'S NAME (Type)		Bernard O. Thomas, Jr., M. D.		Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-60		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy Cemetery		22d. LOCATION (City, town, or county) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4551

CERTIFICATE OF DEATH

64516

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 15 East Third Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 East Third Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CHARLOTTE	Middle AGNES	Last KIMMELL	4. DATE OF DEATH	Month April	Day 18,	Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH April 15, 1882	9. AGE (In years at 1st birthday) 78	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Kimmell		14. MOTHER'S MAIDEN NAME Emma Whipp						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT Miss Maud E. Davis—Same as Item #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>120.1</i> <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cardio-vascular</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>12 months</i> <i>6 months +</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Frederick</i>	(County) <i>Maryland</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>June</i> , 1940, to <i>April 15, 1960</i> that I last saw the deceased alive on <i>April 15, 1960</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Professional Building</i>								
ACTUAL SIGNATURE <i>B. O. Thomas</i> DATE SIGNED <i>4/22/60</i>								
PHYSICIAN'S NAME (Type) B. O. Thomas, M.D. Frederick, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1960		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE APR 25 '60	24b. REGISTRAR'S SIGNATURE Orville S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

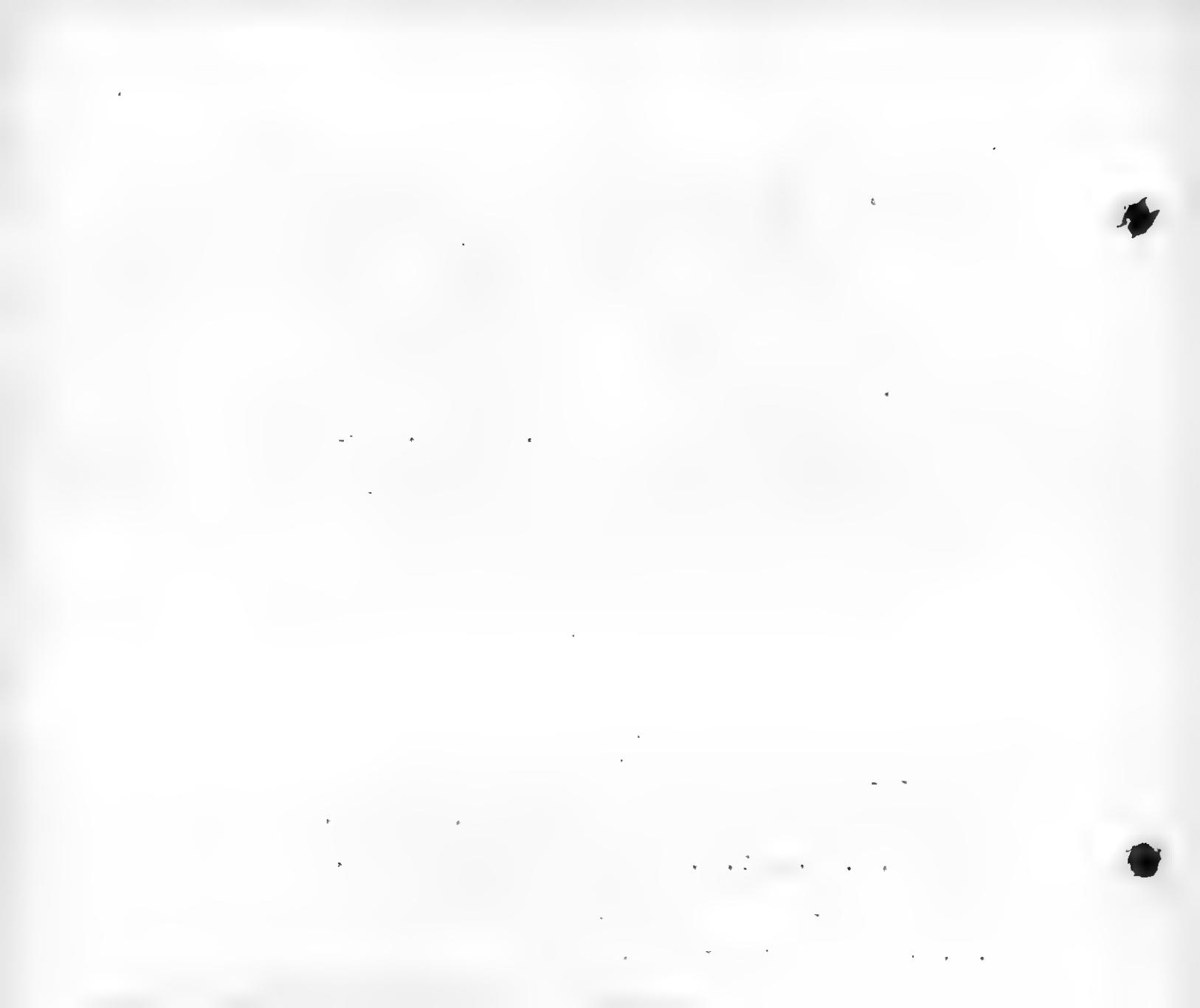
4571 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, copy the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7		c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital				d. STREET ADDRESS Edgewood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle PHILIP	Last KLINE	4. DATE OF DEATH	Month April	Day 6,	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1 Sept 1891	9. AGE (In years last birthday) 88	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin L. Kline		14. MOTHER'S MAIDEN NAME Hannah Burrier					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Beulah M. Masser (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		DUE TO Buckets pneumonia				INTERVAL BETWEEN ONSET AND DEATH 76 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Clinical cardiac disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 24, 1960</u> , to <u>Apr. 6, 1960</u> , that I last saw the deceased alive on <u>Apr. 6, 1960</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 7 N. Market St.	
ACTUAL SIGNATURE H. F. Kline						DATE SIGNED 8 Apr 1960	
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.				Frederick, Md.			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-60		22c. NAME OF CEMETERY OR CREMATORIUM Rocky Springs Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4552

CERTIFICATE OF DEATH

1:4518
Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland		b COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X		d STREET ADDRESS Frederick Route # 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. DATE OF DEATH April 21,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie May Haifleigh		First	Middle	Last	Month	Day	Year
4. SEX Female		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	7. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1880	9. AGE (in years less birthday) 80	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lucinda Haifleigh					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT Millard H. Lindsay		Address Frederick Route # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 5 hours					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 131X		Cerebral hemorrhage					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b		DUE TO					
{		DUE TO					
(b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/21 , 1960, to 4/21 , 1960, that I last saw the deceased alive on 4/21 , 1960, and that death occurred at 8:30 A.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) Libertytown, Maryland					
ACTUAL SIGNATURE M. Schoolman		DATE SIGNED April 23, 1960					
PHYSICIAN'S NAME (Type) Dr. L. R. Schoolman		M.D. 228 North Market St. Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 25, '60		22c. NAME OF CEMETERY OR CREMATORIUM Fairmont Cemetery		22d. LOCATION (City, town, or county) (State) Libertytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey Jr.		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 26 '60		24b. REGISTRAR'S SIGNATURE G. H. S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

4553 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

64519

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 17 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont rural									
3. NAME OF DECEASED (Type or print)		First Michael	Middle Anthony	Last Marsh	4. DATE OF DEATH April 9 1960	Month April	Day 9	Year 1960	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
S SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8 April 60	9. AGE (In years lost birthday) yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) USA Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Michael A. Marsh	14. MOTHER'S MAIDEN NAME Janet M. Kendall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Michael A. Marsh	Address Thurmont, Md. RD1;											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19									20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from 8 April 1960 to 9 April 1960, that (I) (we) last saw the deceased alive on 9 April 1960 and that death occurred at 5 PM, from the causes and on the date stated above											22b. DATE SIGNED				
22a. SIGNATURE Robert J. Since		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) RUBERT J. SINCE		22d. ADDRESS Frederick, Md.													
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-60		23c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery			23d. LOCATION (City, town, or county) Lewistown, Md. Fred Co.		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR APR 12 '60		25b. REGISTRAR'S SIGNATURE Cathia S. Krause									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4554

CERTIFICATE OF DEATH

64520

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the funeral director. The registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 25 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospice, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 138 East South St.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle Ezra	Last Oden	4. DATE OF DEATH April 26 1960	Month April	Day 26	Year 1960				
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. B. DATE OF BIRTH 7-28-1887	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Furniture Dealer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME William H. Oden		14. MOTHER'S MAIDEN NAME Virginia Becroft										
15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-10-5011		INFORMANT Earl F. Oden- 102 Penna. Ave.-Frederick-Md.		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Santo- intestinal hemorrhage Gastric ulcer				INTERVAL BETWEEN ONSET AND DEATH 0 days Unknown						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Professional Bldg.		20f. (City or town) Frederick		(County) Maryland		(State)		
21. I certify that I attended the deceased from alive on 4/26 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Professional Bldg.		DATE SIGNED		
ACTUAL SIGNATURE <i>James B. Thomas</i>												
PHYSICIAN'S NAME (Type) Dr. James B. Thomas												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-1960		22c. NAME OF CEMETERY OR CREMATORIUM Frederick Mem. Park		22d. LOCATION (City, town, or county) W. of Frederick- Maryland		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Dalley's Funeral Home- Frederick- Maryland by E. J. Whitmore		ADDRESS Frederick- Maryland		24a. REC'D BY REGISTRAR DATE MAY 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4555

CERTIFICATE OF DEATH

Reg. Dist. No. 64561

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN TB <i>1 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Daysville</i>		d. STREET ADDRESS <i>1</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Rose</i>	Middle <i>IDEELLA</i>	Last <i>REDDICK</i>	4. DATE OF DEATH	Month <i>April</i>	Day <i>13</i>	Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Feb. 25, 1874</i>	9. AGE (In years last birthday) <i>86</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Avon Co. - Cosmetics</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Orva R. Reddick</i>	14. MOTHER'S MAIDEN NAME <i>Laura L. Valentine</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Mrs. Elva Fowble, Daysville, Md.</i>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>Severe electrolyte imbalance</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Urinary tract infection - passed away</i>				10. days <i>1st, severe</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Auto accident - passed away</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Maryland</i>	(County) <i>Maryland</i>	(State) <i>Maryland</i>		
21. I certify that I attended the deceased from <i>April 11, 1960</i> , to <i>April 13, 1960</i> , that I last saw the deceased alive on <i>April 13, 1960</i> , and that death occurred at <i>8:05 P.M.</i> from the causes and on the date stated above.								DATE SIGNED <i>April 14, 1960</i>
ACTUAL SIGNATURE <i>Ernest A. Dettbarn</i>								ADDRESS (Street, city or town, state) <i>Maryland</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/16/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chapel</i>	22d. LOCATION (City, town, or county) <i>Maryland</i>	(State) <i>Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Barton</i>		ADDRESS <i>Walkersville, Md.</i>	24a. REC'D BY REGISTRAR <i>APR 18 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Orval S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar.

785.6

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

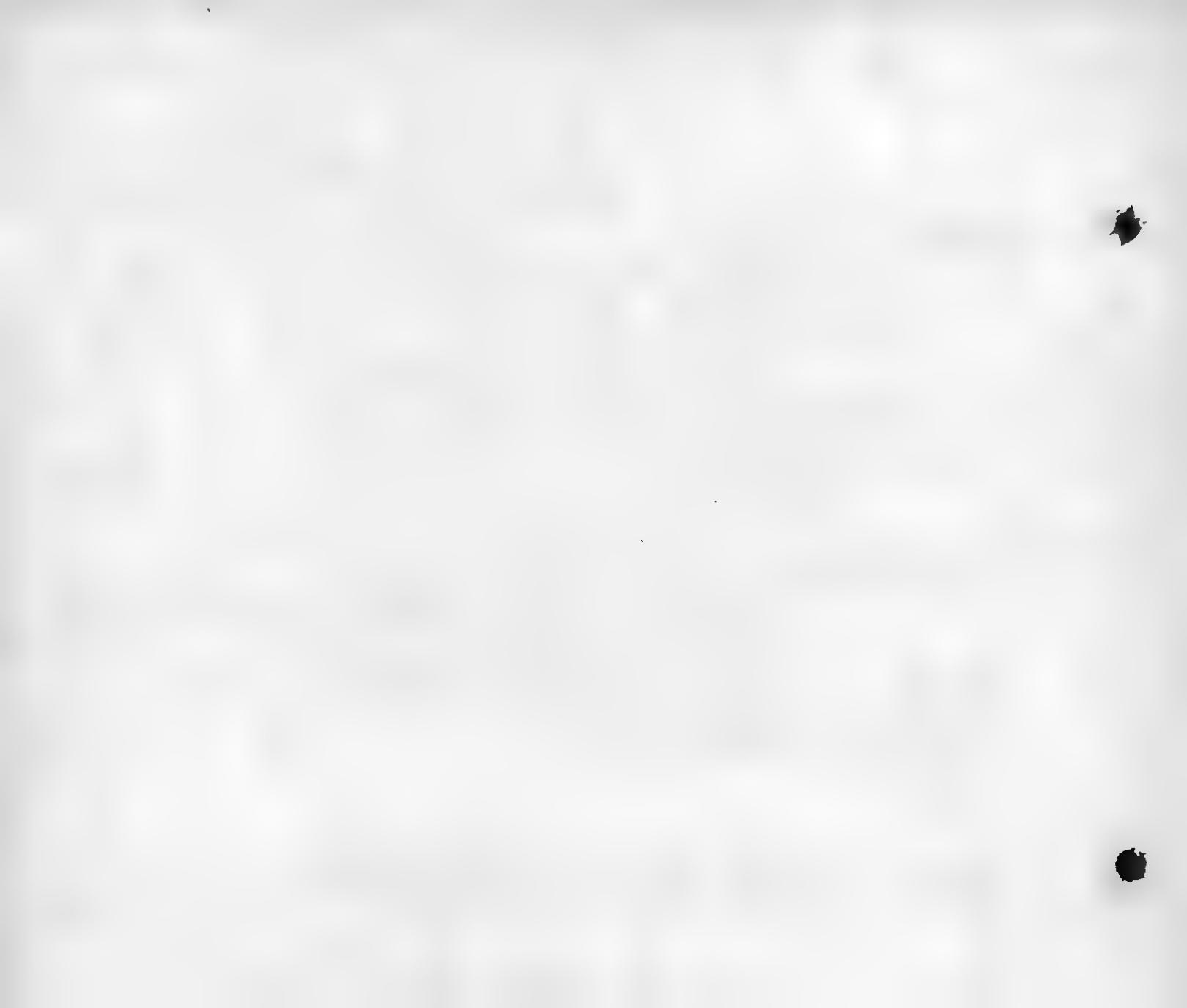
FOR STATE
HEALTH DEPT.

Rec'd Date 4/5/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMQ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4475		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)	
<i>Frederick</i>				a. STATE <i>Md.</i>	b. COUNTY <i>Hartley</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Route 97 mile East of Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hartley</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS PERSON 474 ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Vincent</i>	Middle <i>F</i>	Last <i>Rehak</i>	4. DATE OF DEATH <i>April</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>March 3, 1932</i>	Month <i>4</i> Day <i>4</i> Year <i>1960</i>
8. WIDOWED <input type="checkbox"/>		9. DIVORCED <input type="checkbox"/>	10. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i>		11. BIRTHPLACE (State or foreign country) <i>Brooklyn New York</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Navy</i>		10b. 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
13. FATHER'S NAME <i>Joe Torreto</i>		14. MOTHER'S MAIDEN NAME <i>Louise Rehak</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <i>U.S. Navy</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. & Mrs. Rehak</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Broken neck</i> Candidtans, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Fractured skull</i>	
19. DUE TO (b) <i>Fractured skull</i>		20. DUE TO (c) <i>Fractured skull</i>		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PR.MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Automobile struck guard rail + threw out of car</i>	
20c. TIME OF INJURY Hour <i>11:30</i> a.m. Month, Day, Year <i>4/4/60</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) <i>Route 97 in Emithsburg Frederick Md</i>	
20f. (City or town) <i>Emithsburg</i>		20g. (County) <i>Frederick</i>		20h. (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>4/5/60</i>	
EXAMINER'S NAME (Type) <i>B. O. Thomas</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/9/60</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Hartley Church yard</i>	
22d. LOCATION (City, town, or locality) <i>Hartley</i>		22e. (State) <i>Md.</i>		24b. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		24c. DATE APR 8 '60		24d. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4556

CERTIFICATE OF DEATH

64523

1. PLACE OF DEATH
a. COUNTY

Frederick MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

0149 Frederick Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Frederick - Rural RD#4

d. STREET ADDRESS

Near Feagaville

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

March 28, 1960

9. AGE (In years
last birthday)
yrs.10. IF UNDER 1 YEAR
Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Infant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?
United States

13. FATHER'S NAME

Grayson Edward Hippo

14. MOTHER'S MAIDEN NAME

Charlotte Trail Main

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Res. no. or unknown)

NO

(If yes, give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Address

Hospital for a Mother

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

X 16

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Incontinency

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 28 March 1960, to 21 March 1960, that (I) (we) last
saw the deceased alive on 31 March 1960, and that death occurred at 3 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

Burial

4-1-60

23c. NAME OF CEMETERY OR CREMATORIUM

Mount Olivet Cemetery

23d. LOCATION (City, town, or county)

Frederick, Maryland

22b. DATE
SIGNED

M.D.

ATTENDING
PHYS

MED

DIRECTOR

STAFF

PHYS

22d. ADDRESS

613 1/2 St. Frederick, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

ADDRESS

25a. REC'D BY REGISTRAR

DATE APR 4 '60

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

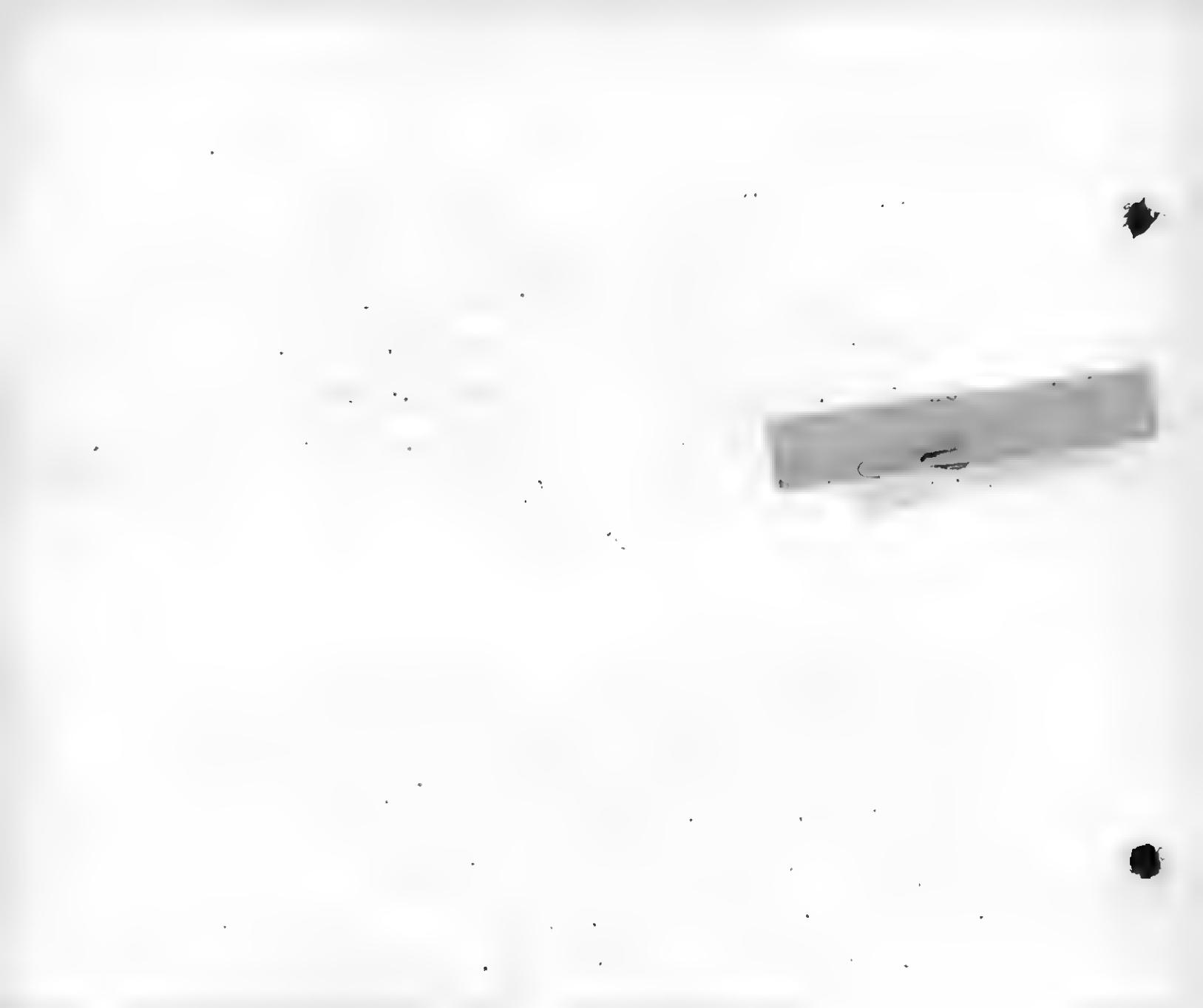
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4572 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Browningsville		d. STREET ADDRESS RFD 1, Monrovia			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gas House Pike				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Margaret Royston		First	Middle	Last	4. DATE OF DEATH April 30 1960	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1882	9. AGE (in years last birthday) 78 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles W. Butler		14. MOTHER'S MAIDEN NAME Margaret Jenkins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. -----		INFORMANT Mrs Sarah J. Snyder, Monrovia, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Cerebral Thrombosis		DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 228 N. Market St.		20f. (City or town) Washington, D.C.		(County) -----	(State) -----
21. I certify that I attended the deceased from _____, 1960, to _____, 1960, that I last saw the deceased alive on _____, 1960, and that death occurred at 2P.		22. ADDRESS (Street, city or town, state) 228 N. Market St.							
ACTUAL SIGNATURE James B. Thomas, M.D.		DATE SIGNED 5/2/60							
PHYSICIAN'S NAME (Type) James B. Thomas		23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Wohlsworth							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Glenwood		22d. LOCATION (City, town, or county) Washington, D.C.		(State) -----	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Wohlsworth		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE MAY 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4573 CERTIFICATE OF DEATH

64525

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Elvin	Middle R.	Last Schildt	4. DATE OF DEATH April 5	Month 1960	Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH June 8, 1887	9. AGE (in years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David W. Schildt		14. MOTHER'S MAIDEN NAME Elizabeth B. Jones					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WWI		INFORMANT Edwin B. Schildt		Address Rocky Ridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO type		Heart disease, hypertension arteriosclerotic type				INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15, 1959</u> to <u>Apr 5, 1960</u> that I last saw the deceased alive on <u>Mar. 28, 1960</u> , and that death occurred at <u>3 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE James K. Gray				ADDRESS (Street, city or town, state) Thurmont - Md		DATE SIGNED Apr. 6-1960	
PHYSICIAN'S NAME (Type) James K. Gray		Thurmont, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-60		22c. NAME OF CEMETERY OR CREMATORIUM Church of Brethren Cem.		22d. LOCATION (City, town, or county) Rocky Ridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR APR 11 1960		24b. REGISTRAR'S SIGNATURE L. Kraus	

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X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4564

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 10 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Emmitsburg		d. STREET ADDRESS 115 W. Main St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 W. Main St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ernest		First	Middle	Last	4. DATE OF DEATH April 18,	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 4, 1876	9. AGE (In years last birthday) 34 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Adams Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Shriver		14. MOTHER'S MAIDEN NAME Mary Weikert						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ernest R. Shriver Emmitsburg, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senility</i> DUE TO <i>arterio sclerotic cardiovascular disease</i> INTERVAL BETWEEN 422.1 <i>Several years</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Several years</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month a. st. 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <i>April 18</i> , 1960, to <i>April 18</i> , 1960, that I last saw the deceased alive on <i>April 18</i> , 1960, and that death occurred at <i>1039</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>W.R. Cadle</i> ADDRESS (Street, city or town, state) <i>Gettysburg, Adams Co. Pa.</i> DATE SIGNED <i>4-19-60</i> PHYSICIAN'S NAME (Type) <i>W.R. CADLE</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/60	22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery			22d. LOCATION (City, town, or county) Gettysburg, Adams Co. Pa. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Milton Bender</i>		ADDRESS Gettysburg, Pa.	24a. REC'D BY REGISTRAR APR 20 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Mann</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4574

CERTIFICATE OF DEATH

No. 1546

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Airview		d. STREET ADDRESS Route # 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVIS		First Luther	Middle SCHROYER
Last		4. DATE OF DEATH April 12 1960	
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH Dec. 27, 1875		9. AGE (In years last birthday) 84 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Gen. Farm	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Schroyer		14. MOTHER'S MAIDEN NAME Dellilah Pryor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mr. M. J. Schroyer, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 4-5 min.	
DUE TO Coronary Arteriosclerosis		unknown	
DUE TO Generalized Arteriosclerosis		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/24</u> , 1960, to <u>4/11</u> , 1960, that I last saw the deceased alive on <u>4/11</u> , 1960, and that death occurred at <u>6:35A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Middleton, Md.</u> DATE SIGNED <u>4/14/60</u>	
ACTUAL SIGNATURE <u>Kenneth C. Henson</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Kenneth C. Henson</u>		Niddletown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Walk U.B.		22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>		ADDRESS <u>Paul F. Bittle, Myersville, Md.</u>	
24a. REC'D BY REGISTRAR APR 18 1960		24b. REGISTRAR'S SIGNATURE <u>John C. Henson</u>	
DATE			

926.1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Coroner's Office, and give Pages 4, 5, and 6 to the Chief Medical Examiner's Office along with Form PHM3. Page 5 may be retained for your files.

FORWARD TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PHM3. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. FILE FORM PHM3 AND 2 WITH THE STATE BOARD OF HEALTH OR ITS DESIGNATED AGENT, PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

VS A15ME
SM 2/57

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Rec'd: 4/15/60

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		Frederick		a. STATE Maryland b. COUNTY Frederick	
c. LENGTH OF STAY IN lb		18 hrs.		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Frederick Memorial Hospital		Thurmont R.F.D.I.	
e. STREET ADDRESS				IS RELATIVE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles	Middle M	Last Shuff	4. DATE OF DEATH April
5. SEX		6. COLOR OR RACE Male White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1939	9. AGE (In years last birthday) 20 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Barber Employee		11. BIRTHPLACE (State or foreign country) Frederick Co.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Shuff		14. MOTHER'S MAIDEN NAME Ruth Hurley		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-36-1552		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Subdural Hematoma, massive, right			
Conditions, if any, which gave rise to immediate cause (b)					
DUE TO (a), stating the underlying cause first (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Automobile crossed road and ran into a tree		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY 2-35 <input checked="" type="checkbox"/> 4/3/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 15	
20f. (City or town) Catoctin Furnace		20g. (County) Frederick		Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 4, 1960	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		22b. DATE THEREOF 4-7-60			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery		22d. LOCATION (City, town, or county) Lewistown Fred Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE APR 7 '60	
				24b. REGISTRAR'S SIGNATURE <i>Charles & Krause</i>	

OS - CNTL, 1100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

64529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>		d. STREET ADDRESS <i>219 W. Patrick</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Ricky</i>	Middle <i>Allen</i>	Last <i>Smith</i>	4. DATE OF DEATH <i>April 9 1960</i>	Month	Day	Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>27 March 1940</i>	9. AGE (In years last birthday) — yrs — months — days	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Robert Lee Smith</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Lee Ball</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>570.3</i>		DUE TO <i>Gangrene, small bowel</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Volvulus</i>		DUE TO <i>—</i>						
DUE TO <i>—</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>2-24-60</i> to <i>10-17-60</i> , that I last saw the deceased alive on <i>10 April 1960</i> , and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>—</i>						DATE SIGNED <i>—</i>
ACTUAL SIGNATURE <i>Am. Powell, Jr.</i>		M.D.						
PHYSICIAN'S NAME (Type)		Medical Center Frederick, Maryland.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/11/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>RILEYVILLE CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>RILEYVILLE, VIRGINIA.</i>		
23. FUNERAL DIRECTOR OR FUNERAL HOME <i>Arthur S. Powell</i>		ADDRESS <i>FREDERICK, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 5 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Powell</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4575 CERTIFICATE OF DEATH

64530

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L55 10M

1. PLACE OF DEATH

COUNTY FREDERICK
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN WOODSBORO

MARYLAND

LENGTH OF STAY
(In this place)

YEARS

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY FREDERICK

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWNWOODSBORO

(If rural give location)

STREET
ADDRESS3. NAME OF
DECEASED
(Type or Print)(First) WEBSTER (Middle) ROLAND (Last) SMITH4. DATE (Month) (Day) (Year)
OF DEATH APRIL 22 19 605. SEX M6. COLOR OR
RACE W7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) M8. DATE OF BIRTH
NOV 3-18789. AGE last birthday
81 yrs.IF UNDER 1 YEAR
MonthsIF UNDER 24 HRS.
Days Hours Min.10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) BAKER OWNER10b. KIND OF BUSINESS
OR INDUSTRY BAKERY

11. BIRTHPLACE (State or foreign country)

MARYLAND12. CITIZEN OF WHAT
COUNTRY? USA

13. FATHER'S NAME

CALVIN P SMITH

14. MOTHER'S MAIDEN NAME

ELIZABETH ALBAUGH15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) NO (If Yes, give war or dates of service)16. SOCIAL SECURITY NO. 118-32-2680

17. INFORMANT & ADDRESS

LELA C SMITH WOODSBORO MDINTERVAL BETWEEN
ONSET AND DEATH

II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Carcinoma of stomach, with
 ANTECEDENT CAUSE(S) DUE TO metastases to liver, peritoneum, skin
 DISEASES OR CONDITIONS, IF ANY, (B) 2 years
 GIVING RISE TO THE ABOVE CAUSE DUE TO
 STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
White Not white
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 19 59, to 4/22 19 60, that I last saw the deceased
 alive on 22 Apr 19 60, and that death occurred at 2:10 P.M. from the causes and on the date stated above.

SIGNATURE

James H. Tamm

ADDRESS (Street, city, town, state)

DATE SIGNED

M.D.

Walker J. Tamm 4/23/6023. BURIAL, CREMATION,
REMOVAL (SPECIFY)
BURIAL

DATE THEREOF

4/25/60

NAME OF CEMETERY OR CEMINATORY

MT HOPE

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR
APR 27 '60

DATE

REGISTRAR'S SIGNATURE
Arthur S. Friend

25. FUNERAL DIRECTOR'S SIGNATURE

John Hartley New Windsor, Md
Thomas Powell Woodsboro, Md

ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4559

CERTIFICATE OF DEATH

4551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK			c. LENGTH OF STAY IN 1b 1 Day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #2, FREDERICK		
3. NAME OF DECEASED (Type or print) Wayne Eileen Thompson			4. DATE OF DEATH Month April Day 5 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 07, 1960		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Frederick, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Herbert E. Thompson			14. MOTHER'S MAIDEN NAME Virgie L. Lee		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Herbert E. Thompson (Same as item #2)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postmaturity Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 116X (b) ? Endometritis DUE TO DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH Unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/5 , 1960, to 4/5 , 1960, that I last saw the deceased alive on 4/5 , 1960, and that death occurred at 11:28 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE James B. Thomas			ADDRESS (Street, city or town, state) 228 N. Market St.		
PHYSICIAN'S NAME (Type) James B. Thomas			DATE SIGNED 4/6/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-60		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy Cemetery	
22d. LOCATION (City, town, or county) Beallsville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE APR 8 '60		24b. REGISTRAR'S SIGNATURE John S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please repeat carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

64502
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b RURAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Frederick Co.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, Rt. # 3, Frederick, Md.		d. STREET ADDRESS Frederick, Maryland.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AUSTIN DANIEL WACHTER.		First	Middle	Last	4. DATE OF DEATH April 15, 1960	Month	Day	Year	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 8, 1891.		9. AGE (In years lost birthday) 69 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxidermist, Retired.		11. BIRTHPLACE (State or foreign country) Frederick County Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME HOWARD M. WACHTER		14. MOTHER'S M AIDEN NAME MICHELE GEASEY									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-16-1011		17. EXAMINER Howard W. Wachter		Address Rte. # 3, Frederick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Aneurysm Ruptured DUE TO 451X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 48 hours											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Charlesville		(County) Frederick Co.		(State) Md.	
21. I certify that I attended the deceased from April 14, 1960 , to April 15, 1960 , that I last saw the deceased alive on April 14, 1960 , and that death occurred at 5:24 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7, East Church St. Frederick. DATE SIGNED 4-15-60											
ACTUAL SIGNATURE Robert S. Turner, Jr.		M.D.									
PHYSICIAN'S NAME (Type) ROBERT S. TURNER JR. MD.		22c. NAME OF CEMETERY OR CREMATORIAL Zion Reformed Church, Charlesville, Maryland.									
22a. BURIAL, CREMATION, OR REMOVAL BURIAL		22b. DATE THEREOF April 18, 60		22d. LOCATION (City, town, or county) Charlesville, Maryland.		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME		ADDRESS FREDERICK, MARYLAND		24a. REC'D BY REGISTRAR Arthur S. Krause		24b. REGISTRAR'S SIGNATURE Arthur S. Krause					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4576

CERTIFICATE OF DEATH

64503

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Thurmont rural

c. LENGTH OF STAY IN 1b

40 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Own Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Thurmont RD 1

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First Mattie M. Weaver

Middle

Last

4. DATE
OF
DEATHMonth April
Day 20, 1960
Year

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

8-21-~~50~~ 19159. AGE (in years
last birthday)

44

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

Hours

Min.

10a. JEWISH OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel C. Eaton

14. MOTHER'S MAIDEN NAME

Grace Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

None

17. INFORMANT

James H. Weaver Thurmont, Md. RD 1

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carcinoma of the breast

INTERVAL BETWEEN
ONSET AND DEATH

18 months

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED

While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2/1/1960 to 4/18/1960, that (I) (we) last saw the deceased alive on 4/18/1960 and that death occurred at 5:22 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Richard C. Reynolds

M.D.

ATTENDING
PHYSMED
DIRECTORSTAFF
PHYS22b. DATE
SIGNED
4/22/6022c. PHYSICIAN'S
NAME (Type)

Richard C. Reynolds

22d. ADDRESS

9 E. Church St. Frederick, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

4-23-60

23c. NAME OF CEMETERY OR CREMATORIUM

Lewistown Cemetery

23d. LOCATION (City, town, or county)

Lewistown Fred Co. Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Creager

ADDRESS

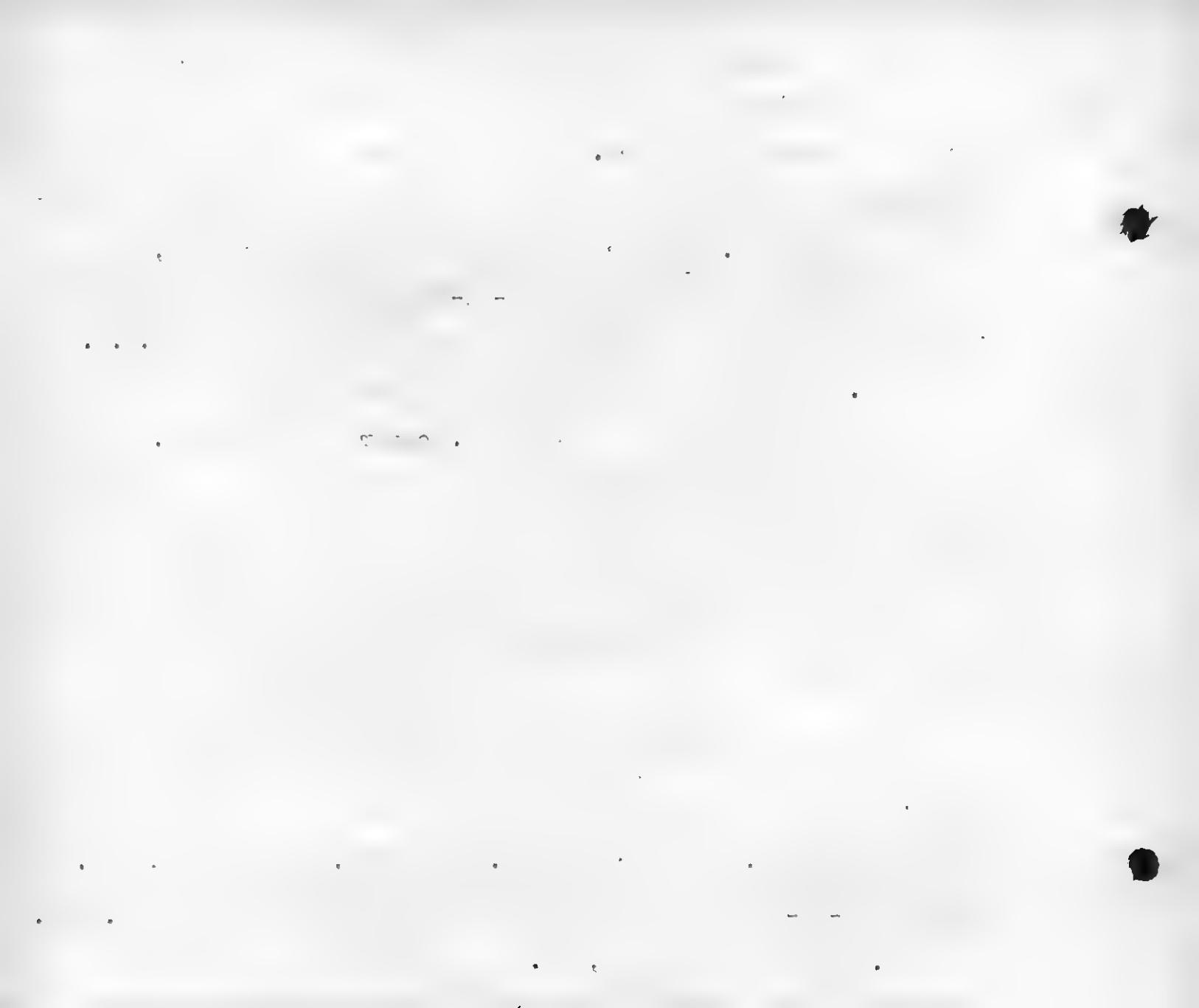
Thurmont, Md.

25a. REC'D BY REGISTRAR

DATE APR 25 '60

25b. REGISTRAR'S SIGNATURE

Clyde S. Kraus



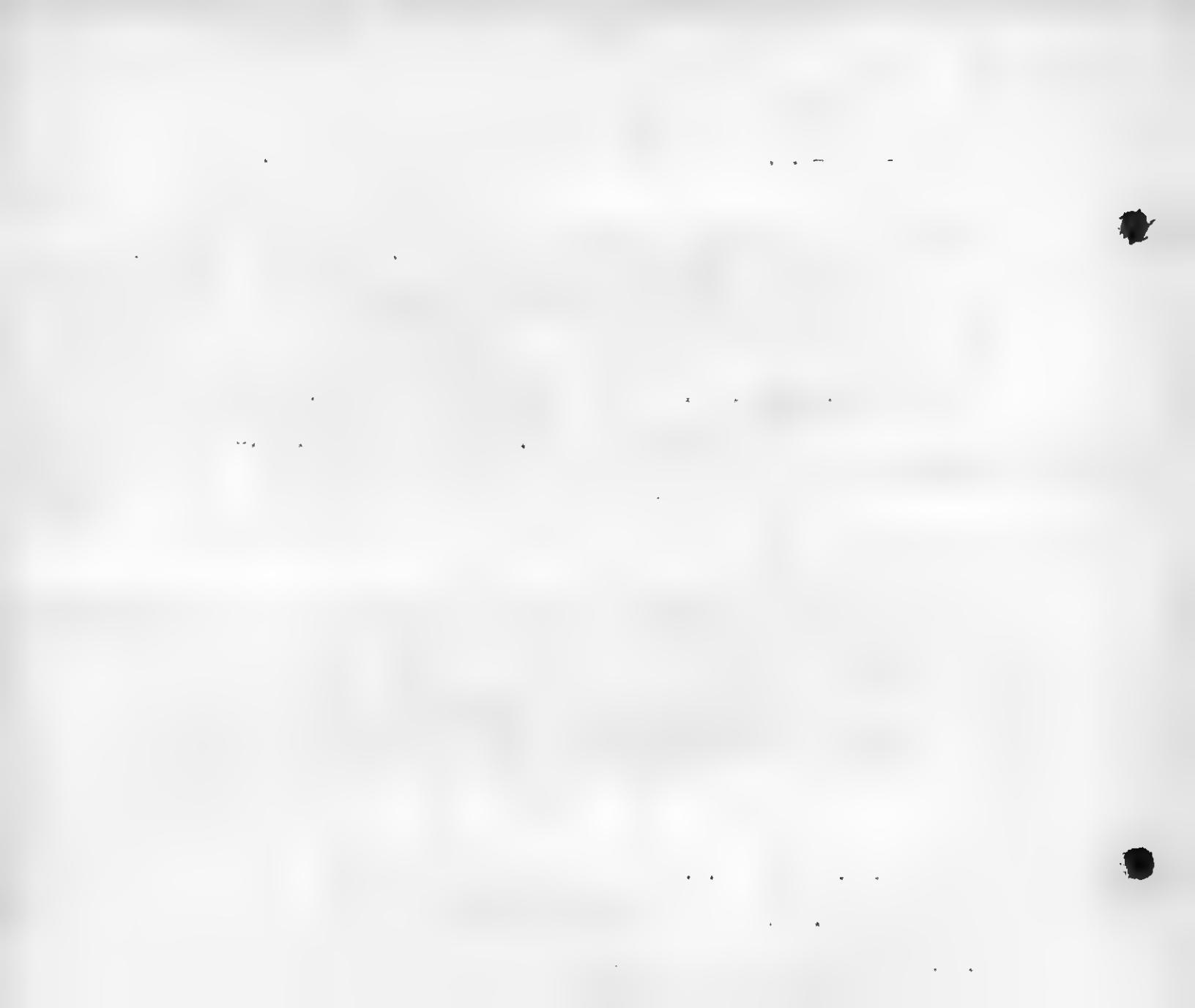
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1804554
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

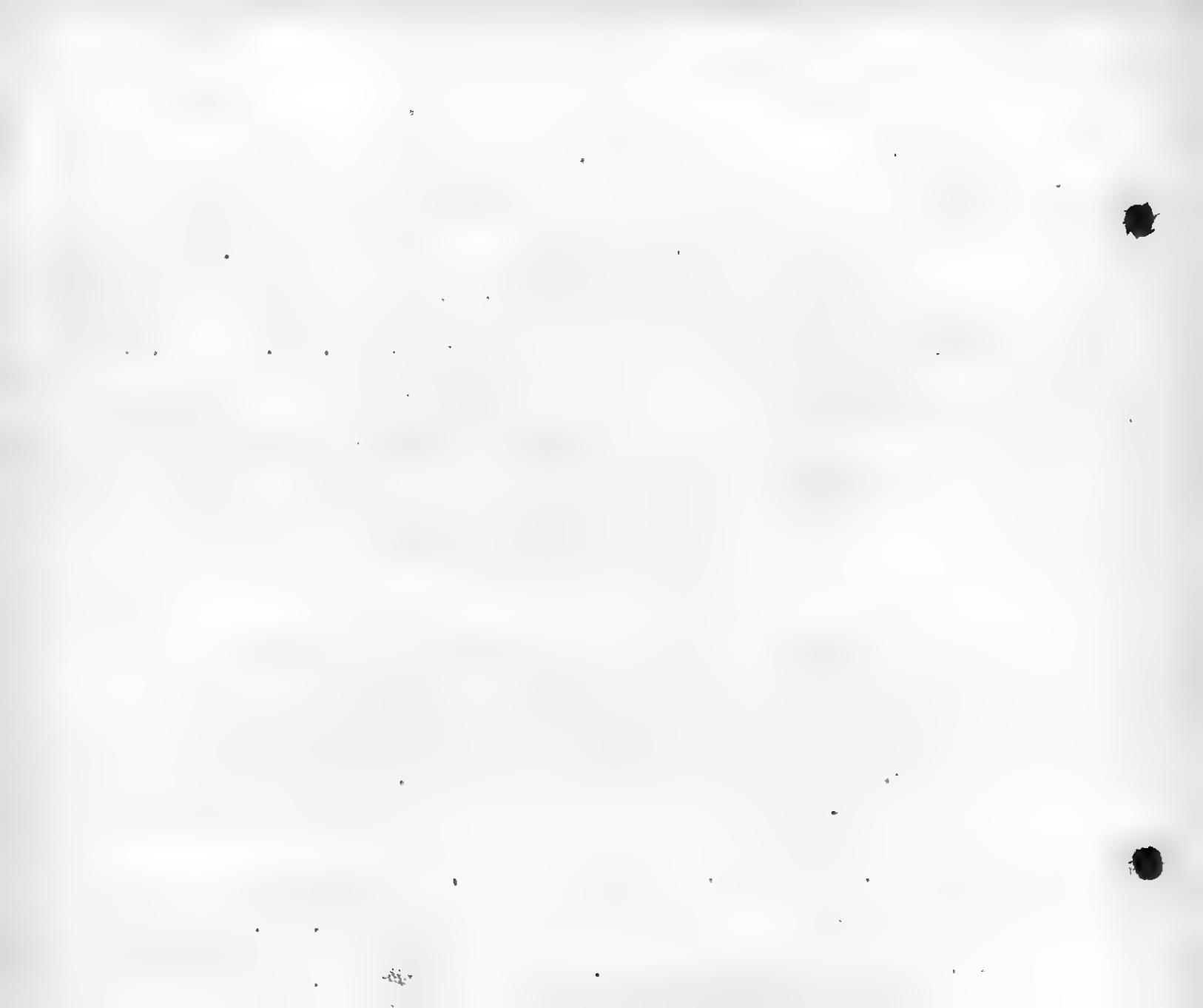
4571		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#3		c. LENGTH OF STAY IN lb Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Bloomfield		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural-R.D.#3	
3. NAME OF DECEASED (Type or print) CHARLES		First LENWOOD	Middle WEDDLE, JR.
4. DATE OF DEATH April		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1945	
9. AGE (In years from birthday) 15 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles L. Weddle, Sr.		14. MOTHER'S MAIDEN NAME Charlotte M. Brunner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Charles L. Weddle, Sr.—Same as item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION		19. INTERVAL BETWEEN ONSET AND DEATH Minutes	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		DATE SIGNED	
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2, Film G260 4/17/60 1b
CERTIFICATE OF DEATH

4561

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, 104 West 6th St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montague Home for aged		d. STREET ADDRESS Montague home for the aged	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Florence	Middle Herbert	Last Weedon
4. DATE OF DEATH	Month Apr.	Day 2	Year 1960
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6-1884
9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lingg Herbert		14. MOTHER'S MAIDEN NAME Harriets Leakins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT Virgie Rickets - Walkersville-Fred. Co.	18. ADDRESS Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4561 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Clarence Maynardite		INTERVAL BETWEEN ONSET AND DEATH 3-175	
DUE TO Retina Detachment		DUE TO 5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1960 , and that death occurred at 8: A.M. on the date stated above.		ADDRESS (Street, city or town, state) M.D. 7717 Market St. Frederick, Md. 21701 DATE SIGNED 4/17/60	
ACTUAL SIGNATURE Virgie		PHYSICIAN'S NAME (Type) H.F. Kline Sr.	
22a. BURIAL CREMATION: REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-60	
22c. NAME OF CEMETERY OR CREMATORIAL Sunnyside		22d. LOCATION (City, town, or county) (State) Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Hicks III		24a. REC'D BY REGISTRAR APR 6 1960	
ADDRESS Frederick - Md.		24b. REGISTRAR'S SIGNATURE Alma J. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4565

CERTIFICATE OF DEATH

64506
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 620 Main Street		d. STREET ADDRESS 620 Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nellie	Middle Ariana	Last Weller
4. DATE OF DEATH April 17,	Month 1960	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5, 1883
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Dean		14. MOTHER'S MAIDEN NAME Laura V. Gonso	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT Mr. Frank A. Weller		Address 620 Main St. Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hyperensive CardioVascular Disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 month years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Rectal hemorrhage for 6 mos - cause unknown	
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) M.D.		(County) Damascus, Maryland	
(State) 4-17-1960			
21. I certify that I attended the deceased from April 7, 1960, to April 17, 1960, that I last saw the deceased alive on April 7, 1960, and that death occurred at 5:15 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Gilcin F. Meadows, M.D.		ADDRESS (Street, city or town, state) 4-17-1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-20-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Hollingshead		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4562

CERTIFICATE OF DEATH

64507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 wk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 8 Carver Apts.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Reavy (alias) Reve Sylvester Whiten		First	Middle	Last	4. DATE OF DEATH Apr. 24	Month	Day	Year 19 60
S. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10-1891	9. AGE (In years lost birthday) 69	IF UNDER 1 YEAR Months 69	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmers Laborer		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lewis Whiten		14. MOTHER'S MAIDEN NAME Harriet Weedon						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Bertie Goins -8 Carver Apts. Fred. Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 10 days (3)		
DUE TO (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Co. Md.	(State) Md.	
21. I certify that I attended the deceased from 16 April 1960 to 24 Apr. 1960 that I last saw the deceased alive on 23 Apr. 1960 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 4/25/60		
ACTUAL SIGNATURE Charles H. Conley Jr.								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-60		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Sunnyside		22d. LOCATION (City, town, or county) Frederick Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks III		ADDRESS Frederick Md.		24a. REC'D BY REGISTRAR APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4563

CERTIFICATE OF DEATH

Ref. 4528
4528

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 103 West Second Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 West Second Street				d. STREET ADDRESS 103 West Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JULIA		First	Middle	Lost	4. DATE OF DEATH April 24,	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 30, 1876	9. AGE (In years last birthday) 83	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME J. Alleine Williamson				14. MOTHER'S MAIDEN NAME Eleanor West McGill					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. Bernhard H. Williamson		17. 1529 Penbridge Road, Baltimore 12, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Congestive Heart Failure Arteriosclerotic Heart Disease Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Cerebral Thrombosis						5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) East Church Street		(County) Frederick	
21. I certify that I attended the deceased from July 1, 1959 to April 24, 1960 that I last saw the deceased alive on April 24, 1960 and that death occurred at 2:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE A. A. Pearre		ADDRESS (Street, city or town, state) 4/27/60							
22a. BURIAL, CREMATION, BIFUL (Specify) Burial		22b. DATE THEREOF Apr. 27, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

